STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILITIES SERVICES INC	2 FREEMAN ST ROSSVILLE, IN 46065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a post certification revisit (PCR) to the PCR completed 02/06/2012 to the PCR completed 12/16/2011 to complaint #IN00097766 investigation completed on November 1, 2011. Complaint # IN00097766 - Corrected. Survey Dates: March 5 and 6, 2012. Facility Number: 001194 Provider Number: 15G628 AIM Number: 100245710 Surveyor: Brenda Nunan, RN, CDDN, PHNS III Abilities Services was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the PCR to the PCR to the investigation of complaint #IN00097766. Quality Review completed 3/14/12 by Ruth Shackelford, Medical Surveyor III.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE